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ABSTRACT

Psychological androgyny is becoming the new standard of mental health at a time when social, political, and economic realities enable women to expand career options. To examine the influence of client sex on the treatment planning of clients, therapists responded to two hypothetical cases of male and female clients whose presenting problem was concerned with career aspirations and deteriorating marital relationships. Results indicated that therapists viewed the male as having an interpersonal relationship problem requiring marital therapy, but expected the female to make concessions in the relationship. The findings indicate that therapists should be aware of the potential negative consequences of encouraging women to meet the needs of others rather than her own needs. (JAC)

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Clinical Bias Against "Activity" in Women and Implications for Female Self-Concept

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Clinical Bias Against "Activity" in Women and Implications for Female Self Concept

Today many women are struggling to change from a dependent life stance with concomitant feelings of low self-esteem and inadequacy to an independent position. Steinmann (1974) describes the traditional concept of the feminine role as one in which the woman conceives of herself as the "other" fulfilling herself by helping others to achieve, that is, a passive woman. A liberal concept of the female role includes a self-achieving orientation whereby the woman strives to fulfill herself directly through her own accomplishments as an active woman. Acceptance of the traditional feminine sex-role stereotype is accompanied by feelings of low self-worth. Research has shown that women who accept society's role prescriptions, have low self-esteem (Birnbaum, 1971).

Due to a combination of political, economic, and social factors, many women today combine traditional and non-traditional roles. U.S. Department of Labor statistics show an increasing number of married woman with children working, especially those with higher education. Since so many women are in multiple roles, mental health practitioners need to be aware of the questions that are raised and how they can best help the women they see. Chesler (1972) maintains that the therapist - patient relationship is psychologically damaging to the female client and asks how a woman can learn to value herself from a therapist who devalues her sex. She says a woman can't win -- she is viewed as maladjusted whether she acts out or rejects the female sex-role stereotype.

A woman who enters psychotherapy is likely to have damaged self-esteem, and be at the crossroads of some sort of decision-making. The imbalance of the therapist-patient relationship gives a great deal of power to the therapist and makes the patient particularly vulnerable to his/her influence (Halleck, 1971). A woman can emerge with a healthy sense of self from this relationship if her unused potential is recognized as legitimate.

A therapist is in double jeopardy of acquiring traditional sex-stereotypic views about the nature of women, both as a member of this culture and in the course of professional training where traditional psychoanalytic views are still widely taught. According to traditional psychoanalytic theory, the little girl, during the phallic phase, recognizes the inadequacy of the clitoris, and therefore gives up masturbation, that is, activity. When she

renounces activity, she turns to her father to be passively loved and moves, according to Freud (1933) from masculinity to femininity. Freud saw the relinquishing of gratification of active and aggressive drive impulses through direct action as a normal developmental process. In this view, a woman who pursues her own goals and strives for self-fulfillment through direct action is considered neurotic. The psychoanalytic concepts of activity and passivity can be thought of as subsuming the attributes comprising the masculine and feminine sex-role stereotypes respectively, such traits as ambitiousness, independence, assertiveness, self-confidence or their lack.

A number of therapists have speculated about the relationship between a traditional view of women's roles and psychotherapy with women. Friedman (1977) believes that both male and female therapists may be inclined to permit in their women patients a greater expression of passivity than they would in their men patients. He says that it is the therapist's responsibility to mobilize unused talents and bring such issues as the following into treatment: discontinuing work because of tensions therein, excessive longings for passivity, guilt over leaving a child with mother substitutes, etc. Nadelson (1974) reiterates the theme of women's guilt over assertive strivings and the therapist's responsibility to help her deal with this guilt. Rice and Rice (1973) see the failure of most therapists in viewing women's role conflicts in intrapsychic terms and not in terms of their social context. Scarato and Sigall (1979) belive that therapists should help the woman shift her attribution of the problem from self-blame to characteristics inherent in her situation. Many clinicians feel that therapy should reflect the changing times and help women overcome cultural inhibitions and guilt about assuming new roles.

Empirical investigation has produced sufficient confirmation of practitioner bias in defining mental health standards for men and women, the result being a more socially acceptable definition of mental health for men (Broverman et. al., 1970; Neulinger, 1968; Nowacki and Poe, 1973). The question currently being raised is how and to what extent the variable of client's sex distorts the assessment and treatment process. Client's sex, alone or in combination with other variables, such as physical attractiveness (Barocas and Vance, 1974) or political orientation (Abramowitz et. al., 1973) has been found to influence clinical prognostic judgements. However, the impact of client's sex upon clinical assessment remains unclear. Billingsley (1977)

found that therapists responded to client pathology rather than client's sex when formulating treatment plans.

The present study was designed to examine the influence of client sex upon the treatment planning of an active client. It was expected that therapist attitudes toward women's rights and roles would be important in the assessment process. Those therapists holding traditional attitudes were expected to differentiate more in their treatment plans on the basis of client sex than those therapists holding "liberated" attitudes toward women. In so far as a therapist accepts traditional views about women, activity would be rejected in women but not in men.

Method

Subjects

Sixty-one volunteer practicing male and female psychotherapists drawn from the disciplines of psychiatry, psychiatric social work, clinical psychology and psychiatric nursing comprised the sample. At the time of the study all were working in the outpatient psychiatry department of urban teaching hospitals in the Northeastern United States. The breakdown by discipline was as follows: 28 social workers, 28 psychiatrists, 2 nurses, and 3 psychologists. The sample was essentially young (70% were in the 20 - 30 age bracket, 22% in the 31 - 40 age bracket, and 8% were over 41 years of age) and inexperienced (42% had less than 2 years experience, 35% had between 2-5 years, and 13% had been working in the field for more than five years). Eighty percent claimed their theoretical oreintation to be psychoanalytic. There were thirty-six female therapists and twenty-five male therapists. The sample as a whole was comprised of young, relatively inexperienced female psychiatric social workers and male psychiatric residents.

Case History

A fictitious case was devised in the format of an intake summary from a typical out-patient psychiatry department. There were two versions

of the same case, identical except for client sex. The case was designed to represent a problem often seen in adult out-patient clinics. Although the client was portrayed as an "active" male or female in work, sex, and interpersonal relationships, the presenting problem was not defined as such. A significant amount of background material was included to make the case believable. The client was active in the sense of being assertive, independent, and ambitious: characteristics which are also subsumed in the masculine sex-role stereotype. In order to validate the case as reflecting activity, four psychiatrists, four social workers, and four psychologists were asked to rate the case as low, medium, or high in terms of activity in the three areas of work, sex, and interpersonal relationships. Ten of the twelve therapists rated the case as high and two gave it medium ratings.

The client in the case description was described as a 28 year old, married person, with no children, who had a master's degree in Journalism and worked as a field reporter for a TV network. The presenting problem was defined as concern about a deteriorating relationship with his/her spouse since taking a new job. The job necessitated some travel and the client was thinking about giving it up, although liking it very much, to make things better at home. The client also questioned whether his/her "drive" was too great. The client described his/her self as always having been ambitious - enjoying the feeling of success for it's own sake.

Procedure

Each subject was individually administered an Instruction and Personal Data Sheet. It described the study as an attempt to look at diff-

erences and similarities in clinical assessment approaches. Subjects were directed to assume that the information in the brief case description was obtained from an intake interview. They were asked to answer the questions following the case as fully as possible despite the limited information provided. Subjects were asked to give the following personal information about themselves: sex, age, marital status, years of professional experience, highest degree attained, and theoretical orientation to therapy. The experimenter took rigorous precautions that each participant had not previously discussed the case with other co-workers.

Two groups were formed on the basis of the client's sex. Half the subjects received the case as a male, the other half received the identical case, except as a female. Subjects were randomly assigned to two groups. Random assignment was accomplished by listing all the subject's names on pieces of paper and then drawing them from a bowl and assigning them alternately to each group. This was done separately for each hospital as data was collected from one institution at a time and equivalent groups were desired across settings. The two groups were comparable according to demographic variables surveyed.

After the treatment plan was finished and returned to the examiner, the 25 item form of the Attitudes Toward Women Scale (AWS) was then given. The scale is designed to measure attitudes toward the rights and roles of women in contemporary society. The shortened version was used to economize on time since it correlated .96 with the full scale 55 item AWS (Spence, Helmreich & Stapp, 1973). The total score

is obtained by summing the values of the individual items; the higher the score, the more liberal or profeminist the attitudes. AWS was administered after respondents completed the questions about the case so as not to contaminate therapist's responses by making them aware of the examiner's interest in sex-role attitudes. A rank ordering procedure was used to create two groups - a liberal and conservative group. Those with scores above the median on AWS were called "liberal" and those with scores below the median were called "conservative." Because of the small number of subjects used, it was not possible to divide the subjects into three groups and use only the high and low thirds.

Data Analysis

Treatment planning was measured by asking therapists to answer four open-ended questions following the case. They were asked: 1) to formulate the patient's problem including speculations about underlying issues, 2) what issues they would explore in therapy, 3) what type of treatment they would recommend, and 4) what their treatment goals would be. Content categories were carefully formulated by the examiner after a thorough investigation of subjects' responses. They were modified until they were considered maximally precise and all inclusive. In order to minimize the possibility of experimenter bias, the coding was repeated by a second observer. The second rater was a doctoral candidate in counseling psychology with several years of clinical experience. AWS scores remained unknown to both coders

at the time of this analysis. The second rater was not informed of the underlying hypotheses of the study. In order to assure reproducibility of the method, the examiner went over a few examples with the second observer. The two code sheets were later compared and a coefficient of inter-rater reliability was computed of .93 (Holsti, 1969).

Results

Frequency distributions were computed for the number of times each content category or theme was chosen for the male and female versions of the case. This was done for each of the four dimensions measuring treatment planning. Since the case was designed to camouflage the activity focus, sufficient background material was included which inevitably resulted in extraneous data being included in therapists' responses. Only those content categories pertinent to the hypothesis under investigation were statistically tested. Chi square analyses were used to test the significance of the difference between the categorical choices for the male and female client. Table 1 summarizes the results. As can be seen, the differences between the two versions were highly significant for each question.

Insert Table 1 about here

There was a significant association of client sex with therapist assessment in terms of problem formulation ($x^2=11.33$, $df=1$, $p < .001$). The problem for the male client was defined as one of marital disagree-

ment. The male client was seen as being angry at his wife for not being more understanding and his wife was seen as being angry at him for being away a lot. The problem for the female client was described in totally different fashion. She was seen as having a conflict about sexual identity and also as being dominant in the marriage.

There was also a significant association of client sex with type of treatment recommended ($x^2=4.52$, $df=1$, $p < .05$). Individual insight-oriented therapy was judged appropriate for the female client whereas couples therapy was considered preferable for the male client. Type of treatment recommended was consistent with their perception of the problem to be an interpersonal one for the male client and an intrapsychic one for the female client. There was a significant association of client sex with treatment goals ($x^2=6.79$, $df=1$, $p < .01$). As could be expected, the main goal of therapy with the male client would be improved communication with his wife. For the female client, the major therapeutic goal would be for her to achieve a satisfactory balance of roles, between home and career.

Subjects' assessments of the major issues that should be explored produced a significant association with client sex ($x^2=5.66$, $df=1$, $p < .05$). For the male case, the focus in therapy would be exploration of both the client's and his wife's perceptions and needs, whereas for the female client, the major issue would be her inappropriate sexual identification necessitating exploration of developmental material pertinent to psychosexual development.

There was no significant interaction of therapist attitudes toward women with client sex upon any dimension of clinical assessment. The hypothesis that conservative therapists would be more rejecting of activity in women than men and that liberal therapists would not differentiate on the basis of client sex in treatment planning was not supported.

In conclusion, client's sex was significantly related to subjects' treatment plans but therapist attitudes toward women was not a significant factor in determining clinical judgments. In each instance, the results were supportive of the clinical speculations about bias against activity in women.

Discussion

The major finding of this study was that therapists do respond to the client's sex when making treatment plans. Bias against activity in women was demonstrated in several ways. First, the female client was seen as having an intrapsychic problem requiring individual insight-oriented therapy whereas the male client, with the same presenting problem of marital conflict, was seen as having an interpersonal relationship problem requiring couples therapy. Activity in a woman was viewed as neurotic in that the conflict was conceptualized as unresolved issues about sexual identification, implying normal femininity had not been achieved. Activity in a male was seen as legitimate and in no way indicative of an underlying neurosis. Bias against activity in the woman patient was also clear from the expectation on the part

of the therapists that she make all the concessions in the relationship - the woman patient was expected to compromise her career ambitions to achieve a more satisfactory balance of the roles of career woman and wife. At no time did therapists suggest that her husband be involved in the treatment nor did they suggest that he make any changes in his life to accomodate her. The male version of the same case procuded very different therapist reactions. He and his wife were seen as being mutually responsible for the resolution of their differences and compromise was expected from both of them.

These findings lend support to the clinical speculations of Friedman, 1977; Kronsky, 1971; Rice and Rice, 1973; etc. They also confirm the findings of the APA Task Force on Sex Bias and Psychotherapy (1975). The task force mentions one instance of bias as being the sexist use of psychoanalytic concepts. In this study, activity was used in a sexist way in that it was seen as inappropriate for the female client but not for the male client. Had therapists in this study been operating from a non-sexist perspective, they would have accepted her ambitious strivings as legitimate and not encouraged her to compromise her career in order to achieve marital harmony. The task force report mentions the therapist's failure to respect the client's assertive behaviors as another instance of sex bias and the therapists in this study exemplified this. The task force also warned against therapists' failing to take account of the

situational factors involved (in this study, the marital context was ignored for the female case but not for the male case). It is significant that the treatment plan for the male case was developed from a system's perspective whereas the plan for the female case was devised from a traditional intrapsychic perspective.

A second objective of this investigation was to examine the impact of therapist's attitudes toward women upon the treatment planning of a male and female client. The findings showed that therapist attitudes did not interact with client sex to significantly influence clinical assessment. There are several possible explanations for the failure to find a significant effect of attitudes toward women. The use of the median to form a liberal and conservative group probably resulted in considerable overlap between the two groups so that the difference between them may have been more arbitrary than real. AWS as a measure of conscious attitudes also allows for social desirability to affect the subject's responses. This sample was probably too sophisticated for such an obtrusive measure. The results of the study clearly indicate unconscious bias did exist against activity in women and a projective type measure would probably have been a more sensitive tool for identifying sexist biases. It is widely recognized that therapists communicate their biases in subtle and uncontrollable ways. Because AWS was validated in 1972 (Spence & Helmreich), it is also possible that it is already out of date as a measure of current sex-role attitudes. It may well be that theoretical or therapeutic orien-

tation would be a better predictor of clinical judgments. Unfortunately, this could not be tested since the sample used in this study was essentially psychoanalytic and the number of therapists from "other" orientations was too small to allow for statistical comparison. However, the data did suggest less differentiation between the male and female cases on the part of those therapists with "other" orientations.

Most therapists did differentiate in their treatment planning of an active case on the basis of client sex. These results assume particular significance at a time when social, political, and economic realities enable women to have opportunities to expand career options. In this study, the hypothetical female client was discouraged from pursuing her career aspirations and asked to renounce her "dominance" in the marriage relationship. It is of interest that this client, who had no children, was expected to subordinate her goals to achieve a better marriage. One can assume that a woman with children would be asked to concede even more should she come to therapy with a similar presenting problem. The findings, of course, are subject to the limitations of the questionnaire method, which is not synonymous with therapist behavior in vivo. It is likely, however, that in an actual clinical situation, therapists unwittingly communicate their biases (nonverbally as well) to an even greater extent. Since the sample was mainly comprised of clinical trainees, discouragement of women from assuming new roles can be seen as a clinical reality for the near future.

Society has placed women in a double bind. Rejection of the traditional female role (wife and mother) leads to a label of "neurotic". Acceptance of the traditional role requires women to exhibit passivity, dependency, and docility and leads to poor self-esteem. According to Wyman and McLaughlin (1979), the major pitfall of the traditional female role is the loss of self-esteem and even of self-identity. They contend that women whose identity is bound exclusively to family roles are particularly vulnerable to impaired self-esteem if they experience disappointments or losses in these significant relationships. By investing herself in multiple roles, a woman has some safeguards for preservation of self. Therapists need to be aware of the potential negative consequences to a woman's basic esteem resulting from encouragement toward meeting the needs of others and not her own.

Psychological androgyny is becoming the new standard of mental health, as opposed to an adjustment model. An androgynous self-concept would allow a person to display both "feminine" and "masculine" behaviorsdepending upon situational requirements (Bem, 1975). Therapists adhering to an androgynous standard of psychological health are more apt to encourage women to pursue their own career goals, regardless of the consequences for the spouse. Therapists working with couples must think in terms of positive personal growth for both partners and be sensitive to the balance of power in the couple system. Role reorganization in human rather than sex-role terms facilitates that end. As therapists focus upon strengths and unrealized potentialities in their women clients, they will be valuable as models of respect and promote self-esteem.

Table 1

Significant Differences for the Male and Female Case

	Male Case	Female Case
	N = 30	N = 31
Formulation of the problem		
Sexual identity conflict	8	20
Mutual anger	13	3 a
Type of treatment recommended		
Individual insight therapy	8	15
Couples therapy	21	12 b
Issues for exploration		
Developmental material	8	20
Spouse's perceptions and needs	11	6 b
Therapeutic Goals		
Improved Communication	14	7
Achieve balance of roles	2	9 c

a $p < .001$ (chi-square test)

b $p < .05$ (chi-square test)

c $p < .01$ (chi-square test)

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